

Maryland AIDs Drug Assistance Program

Filgrastim (Neupogen) Prior Authorization Fax Form

FAX Completed Form to First Health Services Corporation 1-800-932-3921

Questions call First Health Services 1-800-932-3918

Name of Patient: _____ MADAP ID

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Instructions

In order for a MADAP client to receive filgrastim (Neupogen), the client's MADAP certification must remain current and certain medical criteria must be met. For an assessment of the medical criteria, the authorized prescriber must complete and submit this form for authorization.

☐ Yes ☐ No Is this a request to continue a course of uninterrupted treatment? If **NO** go to **Initial Approval** section and if **YES** go to the **Continued Approval** section.

Initial Approval

The prescriber's statement must indicate that the patient is demonstrating neutropenia as indicated by an absolute neutrophil count (ANC) of less than the equivalent of 500 neutrophils/ml within 60 days prior to treatment with filgrastim.

☐ Yes ☐ No Is/Was the patient's ANC less than 500/ml prior to treatment with filgrastim?

Pre-treatment ANC = _____/ml Date: _____

Filgrastim treatment began Date: _____

☐ Yes ☐ No Is filgrastim a required component of the treatment plan for drug induced bone marrow suppression? List Drug: _____

Continued Approval

At 60 day intervals from the date of the Initial PA Approval or last Continued PA Approval, the prescriber's must indicate that the individual has been re-evaluated and the ANC is less than the equivalent of 1,000/ml, or filgrastim is required to treat an on-going drug induced bone marrow suppression. Filgrastim should be discontinued when the ANC exceeds 1,000/ml.

☐ Yes ☐ No Has the patient has been re-evaluated since last PA request for filgrastim?

☐ Yes ☐ No Is the repeat ANC, determined at least 2 weeks after last dose, less than 1,000/ml?

ANC = _____/ml Date: _____

☐ Yes ☐ No Is filgrastim a required component of the treatment plan for and on-going drug induced bone marrow suppression? List Drug: _____

Renewal: Please note that this certification must be renewed every 60 days to continue payment for filgrastim.

Prescriber Information (Please complete legibly)

Name: _____

DEA

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Address: _____

Office Phone:

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Fax:

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Signature: _____

Date: _____